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Recommended Citation

Nygren, Sara Lind () "Organ Donation by Incompetent Patients: A Hybrid Approach," *University of Chicago Legal Forum*: Vol. 2006: Iss. 1, Article 16.

Available at: <http://chicagounbound.uchicago.edu/uclf/vol2006/iss1/16>

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Organ Donation By Incompetent Patients: A Hybrid Approach

Sara Lind Nygren[†]

INTRODUCTION

Organ donation by incompetent patients is a controversial issue that demands special attention from the law in order to protect the rights of incompetent patients. The standards used to make other medical decisions for incompetent patients may be inappropriate in this context, given the lack of any concrete physical benefit to the patient.¹ The selfless nature of organ donation requires that we look more carefully at the current state of the law and alter it as needed for this unique situation. The issue is particularly pressing given the short supply of, and high demand for, organs, which has caused many people to look to incompetent family members as a source of non-vital organs.² This Comment addresses the standards currently used by courts, as well as the alternatives that have been proposed, and ultimately recommends a new hybrid approach tailored to the specific circumstances of the individual incompetent patient.

When a patient lacks the ability to make his or her own medical decisions, a court declares that patient legally incompetent and appoints a guardian.³ It follows that when medical decisions must be made, a surrogate decisionmaker is required. The patient's guardian is typically involved in this process. If the patient is a minor, the guardian is usually a parent, although the

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¹ See, for example, Ray Foemming and Betsy Abramson, *Wisconsin Department of Health and Family Services Division of Supportive Living: Guardianship of Adults: A decision-making guide for family members, friends and advocates* 20-21 (1997) ("Where the procedure involves risk, is irreversible, and does not clearly benefit the individual, a guardian in Wisconsin probably lacks authority to consent for the person.").

² For a general discussion, see John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 Colum L Rev 48 (1976) (discussing the increasing use of intra-familial organ transplants).

³ See *Cruzan v Director*, 497 US 261, 280 (1990) ("An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate.").

court may appoint another guardian; if the patient is an adult, the court will appoint a parent, family member, or other adult as the guardian.⁴ Some courts have held that a judge must make the determination as to the correct medical decision,⁵ while others allow a doctor to make the decision.⁶ When a surrogate makes a medical decision for the patient, the surrogate must act in accordance with a legal standard. Two standards, the "substituted judgment" standard and the "best interests of the patient" standard, are widely used.⁷

The substituted judgment standard, which is more frequently used, attempts to determine what the patient would do if competent to make the decision.⁸ Generally, the decisionmaker looks first to any formal advance health care directives or previous statements about medical decisions, and then addresses the patient's values, any religious beliefs, the effect on the family, and other concerns.⁹ Although this is the dominant standard, several commentators have criticized it. One common criticism is that it is a legal fiction that allows the biases and personal opinions of the decisionmaker to influence the decision.¹⁰

As an alternative, courts have used a best interests of the patient standard. This standard looks objectively at the situation

⁴ See, for example, Anna Schork Fraleigh, *Notes: An Alternative to Guardianship: Should Michigan Statutorily Allow Acute-Care Hospitals to Make Medical Treatment Decisions for Incompetent Patients Who Have Neither Identifiable Surrogates nor Advance Directives?*, 76 U Det Mercy L Rev 1079, 1095-1108 (1999) (describing Michigan's procedures for guardianship appointments).

⁵ See, for example, *Rogers v Commissioner of the Department of Mental Health*, 458 NE2d 308, 310 (Mass 1983) ("If a patient is adjudicated incompetent, a judge, using a substituted-judgment standard, shall decide whether the patient would have consented [to the treatment].") (citations omitted); *Superintendent of Belchertown v Saikewicz*, 370 NE2d 417, 433 ("The Probate Court is . . . the proper tribunal to determine the best interests of a ward.").

⁶ See *Washington v Harper*, 494 US 210 (1990) (holding that the due process clause does not require a judge to make a determination regarding involuntary medication of a prisoner, but, instead, allows prison doctors to make the determination).

⁷ See Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 Rutgers L Rev 1193, 1197 (1996) (describing substituted judgment and best interests as "the decisionmaking standards . . . usually applied to incompetent medical patients who have left no prior instructions").

⁸ See *In re A.C.*, 573 A2d 1235, 1249 (DC App 1990) ("[T]he court . . . [must] determine as best it can what choice that individual, if competent, would make with respect to medical procedures.") (internal quotation marks omitted) (citation omitted).

⁹ *Id.* at 1249-50.

¹⁰ See, for example, Roger B. Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 Health Matrix 235, 250 (2003) ("No matter how one dresses it up, A deciding for B is not an exercise of B's autonomy."); Cantor, 48 Rutgers L Rev 1193 (cited in note 7) (arguing that substituted judgment allows surrogates to make quality decisions for the patient).

and tries to determine what is in the patient's best interests.¹¹ Both medical and psychological factors can be considered.¹² The best interests standard recognizes that it may be impossible to determine what an incompetent patient would really choose to do. This is especially true when the patient has been incompetent his or her entire life. However, the standard is also subject to criticism; for example, it has been criticized for not adequately respecting the patient's autonomy.

This Comment undertakes a cost-benefit analysis of each of the standards, and proposed alternatives, in the context of organ donation. Part I introduces organ donation and legal incompetence. Part II discusses the substituted judgment and best interests standards. It reviews the law in this area and addresses the costs and benefits of each approach, specifically in the context of organ donations. Also, it deals with the costs and benefits of each approach when the patient was previously competent and, alternatively, when the patient has never been competent. Part III discusses alternative standards, focusing on the same concerns addressed in Part II. Part IV will speak to the question of who is the best decisionmaker.

Part V proposes a framework for answering this question. Applying this framework suggests that the substituted judgment standard should be used when the patient was previously competent because it respects the patient's autonomy and helps friends and family to feel that the right decision has been made. However, when the patient has never been competent to make medical decisions, the best interests standard should be used. It is impossible to determine what the patient would have chosen to do when that patient has never been competent to consider and make such a decision. Finally, the decisionmaker should be a hospital ethics committee or review board, comprised of doctors, lawyers, ethicists, and others, to ensure that all viewpoints are considered and that the decision is unbiased.

¹¹ See *In re Conroy*, 486 A2d 1209, 1231 (NJ 1985) (allowing guardians to make medical decisions for incompetent patients "if it is manifest that such action would further the patient's best interests in a narrow sense of the phrase, even though the subjective test that we articulated above may not be satisfied").

¹² See, for example, *Little v Little*, 576 SW2d 493, 499-500 (Tex App 1979) (considering the medical risks and the psychological benefits to the donor).

I. ORGAN DONATION AND INCOMPETENT PATIENTS

Living organ donors typically donate a kidney, part of the liver, or bone marrow.¹³ Under normal circumstances, donation does not involve serious physical risk or pain to the donor.¹⁴ However, the physical risks to the donor should not be minimized, especially in the case of kidney or liver donations, which are major surgeries involving general anesthesia and all the associated risks.¹⁵ Also, in the case of kidney donation, the donor is left with only one kidney, which puts him at a greater risk for kidney complications in the future. Furthermore, at least one commentator argues that donation may involve substantial psychological harms to donors,¹⁶ although others minimize this concern.¹⁷ Siblings are usually the best donors, for reasons including matching blood types and relative ages of the donor and recipient.¹⁸ Sometimes, therefore, the best possible match, and maybe

¹³ Kidneys can be safely donated as long as the donor has another healthy kidney, part of the liver can be donated due to the liver's ability to regenerate itself, and bone marrow can also be donated because of its ability to be regenerated. See Michael T. Morley, Note, *Proxy Consent to Organ Donation by Incompetents*, 111 Yale L J 1215, 1220-22 (2002) (describing the possibility of, and the techniques used for, kidney, partial liver, and bone marrow transplants).

¹⁴ Id at 1221.

¹⁵ See R.W. Strong and S.V. Lynch, *Ethical Issues in Living Related Donor Liver Transplantation*, in Arthur L. Caplan and Daniel H. Coelho, eds, *The Ethics of Organ Transplants: The Current Debate* 44 (Prometheus Books 1998) ("The risk to the donor is that associated with a major operation in the form of perioperative complications and long-term sequelae."); Aaron Spital, *Ethical Issues in Living Related Donors*, in Wayne Shelton and John Balint, eds, *7 The Ethics of Organ Transplantation* 103 (Oxford 2001) ("Donor nephrectomy is a major surgical procedure and postoperative complications are inevitable . . . average postoperative complication rate of 32% . . . most of these were minor.").

¹⁶ See Cara Cheyette, Note, *Organ Harvests from the Legally Incompetent: An Argument Against Compelled Altruism*, 41 BC L Rev 465, 474-80 (2000) (reviewing studies that suggest both kidney donors and bone marrow donors may suffer significant psychological harm). See also Spital, *Ethical Issues in Living Related Donors* at 104 (cited in note 15) ("Psychological complications, especially depression, have also been reported."); Philip Cohen, *Donor's Dread: Why do children who help a sick sibling end up depressed?*, 155 New Scientist 1, 20 (23 August 1997) ("Children who donate . . . suffer from depression, nightmares and low self-esteem, even years later.").

¹⁷ See Morley, 111 Yale LJ at 1223 (cited in note 13) ("[C]laims that organ donation is psychologically harmful to donors are unsupported, and even contradicted, by research results."). See also Deane L. Wolcott, et al, *Psychological Adjustment of Adult Bone Marrow Transplant Donors Whose Recipient Survives*, 41 Transplantation 413, 484 (1986) ("[Bone marrow] donors manifested little emotional distress, high self-esteem, and a high degree of current life satisfaction."); S. Younger, *Organ Donation and Procurement*, in John Craven and Gary M. Rodin, eds, *Psychiatric Aspects of Organ Transplantation* 126 (Oxford 1992) ("[M]ost studies suggest that organ donors have found the experience to be a positive one.").

¹⁸ See Morley, 111 Yale LJ at 1216 (cited in note 13) (explaining the need for a donor of similar age and stature, saying, "members of a patient's immediate family, especially

the only possible match, will be the recipient's incompetent sibling.

Incompetency is defined as a "[l]ack of legal ability in some respect."¹⁹ Looking to a variety of factors, a court determines whether a person is legally incompetent.²⁰ Generally, children are also considered legally incompetent—their parents must make medical decisions for them.²¹ Therefore, it is logically inferred that if a child is born healthy but becomes severely cognitively impaired before becoming an adult, that child has never been competent for purposes of surrogate decisionmaking. However, when patients were close to eighteen before becoming severely cognitively impaired, it is debatable whether their expressed preferences and values should be considered.²² Finally, it is also clear that patients who were born severely cognitively impaired have never been competent.

Incompetence can vary among patients from severe and profoundly impairing, to mild and less impairing. When incompetence is severe, the patient will have limited awareness of his or her surroundings and will often have serious medical conditions. For example, Claire Conroy, an incompetent patient, was "confined to bed . . . she could not speak," and she had numerous medical conditions.²³ When incompetence is at its most severe, the patient may be in a persistent vegetative state, as was Nancy Cruzan.²⁴ This is a "condition in which a person exhibits motor reflexes but evinces no indication of significant cognitive func-

siblings, are among the best potential organ donors") (citations omitted). See also Spital, *Ethical Issues in Living Related Donors* at 104 (cited in note 15) ("[L]iving relatives [are] the preferred source of transplanted kidneys").

¹⁹ Black's Law Dictionary 526 (8th ed 2004). Incompetence is generally defined in terms of incompetence to do a particular thing. For example, we would generally say that a person is "incompetent to make financial decisions" or "incompetent to make medical decisions." This comment deals with patients who are incompetent to make medical decisions.

²⁰ See, for example, Fraleigh, 76 U Det Mercy L Rev at 1082-83 (cited in note 4) (describing Michigan's procedures for determining incompetence).

²¹ Robert W. Griner, *Live Organ Donations Between Siblings and the Best Interest Standard: Time for Stricter Judicial Intervention*, 10 Ga St U L Rev 589, 589 (1994) (noting that parents "have generally been allowed to determine what medical treatment their children are to receive").

²² See, for example, *Hurdle v Currier*, 5 Va Cir 509, 512-13 (Va Cir 1977) (giving parents authority to consent to kidney donation by their minor daughter for her sister, where the mentally competent minor was sixteen years old and the court felt she displayed the maturity to understand the decision to donate). That question is beyond the scope of this Comment, though it is an issue that should be addressed.

²³ *In re Conroy*, 486 A2d at 1217.

²⁴ *Cruzan v Director*, 497 US 261, 266 (1990).

tion.”²⁵ On the other hand, some incompetent patients can talk and have relationships, but do not have the mental ability to make medical decisions due to some mental impairment, such as Downs Syndrome. This was the condition of Jerry Strunk, who was incompetent due to, as the court put it, his “feeble-minded[ness]” and “IQ of approximately 35.”²⁶ The court permitted Jerry to donate an organ.²⁷ The severity of incompetence can therefore vary significantly and should be considered.

II. THE SUBSTITUTED JUDGMENT AND BEST INTERESTS STANDARDS

The right to control one’s own medical decisions is a constitutional right.²⁸ This section lays out this right and traces its development in the context of incompetent patients. Courts differ in their approach to this right and particularly in their approach to applying this right to organ donation by incompetent patients. But they have generally relied on two standards. This section details these two standards—the substituted judgment standard and the best interests standard—and addresses the costs and benefits of each approach.

A. Legal Right at Stake in Organ Donation

The right of patients to refuse or accept medical treatment is protected by the due process clause of the 14th Amendment.²⁹ That clause gives individuals a liberty right to make their own medical decisions.³⁰ Justice Cardozo, in a case involving informed consent, explained that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his

²⁵ Id.

²⁶ *Strunk v Strunk*, 445 SW2d 145, 146 (Ky 1969).

²⁷ Id at 145.

²⁸ See *Rust v Sullivan*, 500 US 173, 202 (1991) (acknowledging a “Fifth Amendment right to medical self-determination”).

²⁹ See *Cruzan v Director*, 497 US 261, 278 (1990) (“The Fourteenth Amendment provides that no State shall ‘deprive any person of life, liberty, or property, without due process of law.’ The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”); *Mills v Rogers*, 457 US 291, 299 (1982) (stating that “the Constitution recognizes a liberty interest in avoiding unwanted administration of antipsychotic drugs”); *In re A.C.*, 573 A2d at 1247 (stating that “every person has a right, under the common law and the Constitution, to accept or refuse medical treatment”). See also, Norman L. Cantor, *The Relation Between Autonomy-Based Rights and Profoundly Mentally Disabled Persons*, 13 Ann Health L 37, 37 (2004) (“People have a Fourteenth Amendment liberty right to make important medical choices.”).

³⁰ Id.

own body.”³¹ Courts and commentators have used this quotation to describe a patient’s right to autonomy in medical decision-making.³² That right was extended to incompetent patients by the Supreme Court of New Jersey in *In re Quinlan*,³³ which firmly established that an incompetent patient’s “right of privacy may be asserted on her behalf by her guardian.”³⁴ The Supreme Court, in *Cruzan v Director*,³⁵ while acknowledging a federal right of privacy, explained that, “under certain circumstances a surrogate may act for the patient.”³⁶ Other courts have reiterated the view that there is an individual right “under the common law and the Constitution . . . of bodily integrity,” regardless of the degree of competence.³⁷

However, these constitutional issues cannot and should not be considered independently of state law.³⁸ Because state law can provide more substantive protection, the federal Constitution defines only a minimum sphere of protection. Therefore, there is no national consensus on what standard is best, or what the standards mean. Federal and state courts have used both standards and given each standard slightly different interpretations.

B. Two Prevailing Standards

Courts have based their decisions to grant requests for organ donation from incompetent patients on both the substituted judgment and best interests standards. One of the first instances of an appellate court upholding a lower court’s approval of organ donation by an incompetent patient was based on the substituted judgment standard. In *Strunk v Strunk*,³⁹ the parents of an incompetent adult child, Jerry, sought court permission to have one of his kidneys removed and donated to his competent

³¹ *Schloendorff v Society of New York Hospital*, 211 NY 125, 129 (NY 1914).

³² See, for example, *Cruzan*, 497 US at 270 (“The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.”).

³³ 355 A2d 647 (NJ 1976).

³⁴ *Id* at 664.

³⁵ 497 US 261 (1990).

³⁶ *Id* at 280. The Court did, however, approve of a clear and convincing evidence standard to determine what the patient would have done. *Id* at 265.

³⁷ *In re A.C.*, 573 A2d 1235, 1247 (DC App 1991).

³⁸ See *Mills*, 457 US at 303 (stating that “[i]f the state interest is broader, the substantive protection that the Constitution affords . . . would not determine the actual substantive rights and duties of persons in the [s]tate”). Furthermore, “state-created liberty rights are entitled to the protection of the federal Due Process Clause.” *Id* at 300.

³⁹ 445 SW2d 145 (Ky 1969).

brother, Tommy.⁴⁰ The court used the substituted judgment standard to determine that Jerry would have authorized the donation, explaining that donating the kidney would be “beneficial to Jerry because Jerry was greatly dependent upon [his brother], emotionally and psychologically, and . . . his well-being would be jeopardized more severely by the loss of his brother than by the removal of a kidney.”⁴¹ However, the fact that all members of the family agreed to the transplant made that case easier for the court to decide.⁴²

Courts have also based their decisions to allow for organ donation on an evaluation of the benefits the patients receive from the donation. For instance, in *Little v Little*,⁴³ a case very similar to *Strunk*, a mother sought permission to have her incompetent daughter donate a kidney to her competent son.⁴⁴ The court did not expressly use a “best interests” standard, but the language is similar to that approach. The opinion discussed the benefits that the patient would receive from having her brother live, stating that there was a “close relationship”⁴⁵ between the siblings, and that the basis for allowing the transplant was “evidence to the effect that she will receive substantial psychological benefits.”⁴⁶ The court also weighed the benefits to the rest of the family and the minimal risks to the patient.⁴⁷ Furthermore, the court believed that,

[a]lthough in *Strunk* the Kentucky Court discussed the substituted judgment doctrine in some detail, the conclusion of the majority there was based on the benefits that the incompetent donor would derive, rather than on the theory that the incompetent would have consented to the transplant if he were competent.⁴⁸

In other words, the *Little* court believed that the *Strunk* court had used a best interests standard. This seems to be a plausible interpretation of the opinion in *Strunk*, which focused

⁴⁰ Id at 145-46.

⁴¹ Id at 146. The court also stressed that Jerry “identifie[d] with his brother Tom; Tom [was] his model.” Id (internal quotation marks omitted). Furthermore, Jerry was the only compatible donor for his brother. Id.

⁴² Id at 147.

⁴³ 576 SW2d 493 (Tex App 1979).

⁴⁴ *Little*, 576 SW2d at 494.

⁴⁵ Id at 498.

⁴⁶ Id at 500.

⁴⁷ Id at 499-500.

⁴⁸ *Little*, 576 SW2d at 498.

almost exclusively on the benefit that Jerry would receive if his brother lived. Another court case allowing organ donation by an incompetent patient to his brother, *In re Doe*,⁴⁹ explicitly used the best interests standard. There, the court found that "the benefits to the incompetent if his brother lives outweigh the physiological and psychological risks."⁵⁰

Some courts, on the other hand, have denied organ transplants from incompetent patients. For example, in *Lausier v Pescinski*,⁵¹ the Wisconsin Supreme Court refused to adopt the substituted judgment standard and would not authorize an organ transplant. The court noted that it had no statutory authority to do so.⁵² Furthermore, the court stated that

An incompetent particularly should have his own interests protected. Certainly no advantage should be taken of him. In the absence of real consent on his part, and in a situation where no benefit to him has been established, we fail to find any authority for the county court, or this court, to approve this operation.⁵³

That court apparently did not believe that adequate benefit to the incompetent patient was shown by the fact that the recipient was a sibling. A Louisiana appellate court also refused to authorize a transplant in *In re Richardson*.⁵⁴ The court argued that because Louisiana law prohibited guardians from making gifts from a minor's estate, it was inconceivable that the law would permit the guardian to authorize what is often referred to as the ultimate gift—an organ.⁵⁵ These are not the only cases of courts refusing to authorize organ transplants from incompetent patients.⁵⁶ However, in most circumstances courts have permit-

⁴⁹ 104 AD2d 200 (NY App Div 1984).

⁵⁰ Id at 201.

⁵¹ 226 NW2d 180 (Wis 1975).

⁵² Id at 181-82.

⁵³ Id at 182.

⁵⁴ 284 So2d 185 (La App 1973).

⁵⁵ Id at 187.

⁵⁶ Most cases deciding whether organ donation is permissible are decided by the lower courts and not appealed; therefore, these cases are unreported. The lack of further reported cases on the subject does not necessarily mean that there are only two cases where donation has not been permitted. See Robertson, 76 Colum L Rev at 53 n 26 (cited in note 2) (acknowledging the possibility of unreported cases which may deny organ transplants from incompetent individuals). For a case prohibiting donation by a minor child, see *Curran v Bosze*, 566 NE2d 1319 (Ill 1990) (refusing to order a bone marrow transplant from a minor child where that child did not have a relationship with the recipient, a half-brother, and therefore would receive no benefit from donating).

ted these transplants to go forward, generally under some form of the best interests standard, although not always explicitly so.⁵⁷

C. Substituted Judgment Standard

Many state and federal courts use the substituted judgment standard, although each may have a slightly different interpretation. Most courts agree that “the substituted judgment inquiry is primarily a subjective one: as nearly as possible, the court must ascertain what the patient would do if competent.”⁵⁸ The general framework suggests that, “the greatest weight should be given to previously expressed wishes of the patient.”⁵⁹ This would include any advance health care directives written by the patient while competent or any serious discussions about the issue with family or friends that the patient had while competent.⁶⁰ Also, while general statements about the treatment deserve some weight, absolute objections to the procedure⁶¹ and clear statements about a desire to undergo a specific procedure should be honored. In the organ donation context, a person might have said, “I will never donate an organ,” or “if a family member ever needs a kidney, I will donate one of mine.”⁶² These kinds of statements provide strong evidence about what the patient would do if competent and should be respected. Less clear statements should be given some weight.⁶³ But statements about medical care generally, rather than organ donation in particular,

⁵⁷ See Robertson, 76 Colum L Rev at 53 (cited in note 2) (“Judicial approval for intra-family transplants from incompetent donors has been obtained in most cases.”); *Little*, 576 SW2d at 497 (acknowledging that intrafamily organ donation by incompetent patients has been approved in most cases). See also, cases allowing organ donation by minor children: *Hart v Brown*, 29 Conn Supp 386, 391 (1972) (upholding parents’ authority to order organ donation by their minor child for the child’s twin sibling); *Hurdle*, 5 Va Cir 509 (giving parents authority to consent to kidney donation by their minor daughter for her sister, where the minor was sixteen years old and would benefit from a continued relationship with her sister).

⁵⁸ *In re A.C.*, 573 A2d 1235, 1249 (DC App 1990) (citations omitted).

⁵⁹ *Id* at 1250.

⁶⁰ See *id* (previously expressed wishes “includes prior statements, written or oral”).

⁶¹ See *In re Boyd*, 403 A2d 744, 751 (DC App 1979) (stating that clear objections to treatment should be respected).

⁶² See *Hurdle*, 5 Va Cir 509 (holding that because the donor initiated conversations with her sister about donating a kidney and seemed to be mature enough to make that decision, the donation should be permitted). Although that case involved a minor child rather than an incompetent patient, it shows that courts will consider clear statements made about the donor’s preferences. The donor in that case was sixteen and the court believed that she was mature enough to decide whether to donate.

⁶³ See *In re Conroy*, 486 A2d at 1230 (holding that the “consistency” and “thoughtfulness” of prior statements weigh on the probative value of the statements).

should be given less weight.⁶⁴ Also, statements made off the cuff and without actual consideration of the issue should be taken with a grain of salt.⁶⁵ Although family or friends could fabricate any of these kinds of statements, we often rely on the ability of the decisionmaker to judge the credibility of testimony based on the demeanor and believability of the witness, and we should do so here.⁶⁶

Courts consider other factors as well. Some courts look to previous medical decisions made by the patient.⁶⁷ Additionally, courts have referenced the patient's "value system,"⁶⁸ and the patient's "religious beliefs, if any."⁶⁹ Some courts also stress the importance of examining "the impact of the decision on the [patient's] family . . . the probability of adverse side effects . . . the prognosis without treatment . . . the prognosis with treatment . . . [and] any other factors which appear relevant."⁷⁰ Finally, one court has said that "the court may supplement its knowledge about the patient by determining what most persons would likely do in a similar situation."⁷¹

Courts generally speak about protecting the autonomy of the patient when using this standard. Although that is the main benefit of this approach, the standard may also benefit the friends and family of the patient. However, there are also costs to this approach that must be considered.

⁶⁴ See *id* ("Another factor that would affect the probative value of a person's prior statements of intent would be their specificity.").

⁶⁵ See *In re A.C.*, 573 A2d at 1251 ("The court should consider the context in which prior declarations, treatment decisions, and expressions of personal values were made, including whether statements were made casually or after contemplation."); *In re Conroy*, 486 A2d at 1230 (explaining that "an offhand remark" does not "constitute clear proof" that the patient would actually want that result).

⁶⁶ See *In re A.C.*, 573 A2d at 1250 ("The court should be mindful, however, that while in the majority of cases family members will have the best interests of the patient in mind, sometimes family members will rely on their own judgments or predilections rather than serving as conduits for expressing the patient's wishes.").

⁶⁷ See *id* ("The court should also consider previous decisions of the patient concerning medical treatment."). See also *In re Boyd*, 403 A2d at 751 (holding that when previous actions indicate the patient has a strong adherence to, and has not vacillated from, a particular viewpoint about treatment, that view should be respected).

⁶⁸ *In re A.C.*, 573 A2d at 1250.

⁶⁹ *In re Moe*, 432 NE2d 712, 732 (Mass 1982).

⁷⁰ *Rogers*, 458 NE2d at 318-19.

⁷¹ *In re A.C.*, 573 A2d at 1251 (citations omitted). The court was clear to say that this should be considered only "[a]fter considering the patient's prior statements, if any, the previous medical decisions of the patient, and the values held by the patient." *Id*.

1. Benefits.

a) *Respect for patient autonomy.* One of the main concerns in this area of the law is respecting the patient's autonomy.⁷² Even if the patient will never be aware of the treatment decision, such as if he is in a persistent vegetative state, he is still a human with equal rights. Just as we would not force a competent adult to give up a kidney, we should not force an incompetent person to do so.⁷³ On the other hand, a blanket rule that incompetent patients could never donate organs would not respect their autonomy either.⁷⁴ The patient may have had a strong desire to donate organs, or may have loved his sibling and done anything to help her. Denying incompetent patients the right to donate their organs, therefore, would treat them as unequals.⁷⁵

The substituted judgment standard attempts to resolve this dilemma—and respect the patient's autonomy—by trying to discern what the patient really would have wanted. Where the patient, while previously competent, expressed a preference for treatment in such a case, the substituted judgment standard reflects and honors this preference. Although a choice made in the past may not be the same choice the patient would make if currently competent, “a person anticipating future medical situations may still have well-developed values” about the desired treatment if he should become incompetent.⁷⁶ Even where no such preference was articulated, looking to the patient's values and other medical decisions may lead to the right decision while

⁷² See Cantor, 48 Rutgers L Rev at 1204 (cited in note 7) (“Substituted judgment focuses on replicating a patient's likely choice and thus serves as a natural vehicle for promoting the self-determination interests cherished in American culture and jurisprudence.”). For a general discussion, see Dworkin, 13 Health Matrix 235 (cited in note 10) (discussing the necessity of respecting patient autonomy over medical paternalism).

⁷³ See Cheyette, 41 BC L Rev at 467-69 (cited in note 16) (arguing that organ donation by incompetent patients should be prohibited and noting that “competent adults are under no compulsion to submit to organ harvests for the benefit of third parties”).

⁷⁴ See Robertson, 76 Colum L Rev at 74 (cited in note 2) (“We may conclude that respect for persons requires that we always presume that [the patient] says no to any intrusive procedure. But if, in fact, [the patient] would have chosen the procedure, he has been treated unequally in a real sense, because, unlike competents, he has been prevented from realizing his choices.”).

⁷⁵ See Morley, 111 Yale LJ at 1218 (cited in note 13) (“[T]he constitutional rights of children and mentally impaired persons . . . are violated when the law fails to provide a mechanism through which proxy consent may be tendered for donation of a nonvital organ to an immediate family member.”); Robertson, 76 Colum L Rev at 62 (cited in note 2) (noting that “transplants from those legally incapable of consent are consistent with and even required by respect for persons if it is clear that the incompetent, if competent, would have consented to the transplant”).

⁷⁶ Cantor, 13 Ann Health L at 39-40 (cited in note 29).

respecting the patient's autonomy. If it does not lead to the right decision, using this standard makes it more likely that the patient would "agree that he had been fairly treated"; at least if the substituted judgment was based on sound reasoning and an attempt to gauge his preferences.⁷⁷ As noted above, expressed preferences may be oral or written statements about preferences and may include conversations with loved ones about the treatment decision.⁷⁸

On the other hand, when a court using a substituted judgment standard "supplement[s] its knowledge about the patient by determining what most persons would likely do in a similar situation,"⁷⁹ that court is not respecting the patient's autonomy. The substituted judgment standard respects autonomy because it is individualized. However, "determining what most persons would likely do in a similar situation,"⁸⁰ appears to be a reasonable-person standard. Even where the probability that most people would make a particular choice is very high, the idiosyncratic patient should not be forced into everyone else's mold. It is not the case that the more idiosyncratic a patient's preferences the less respect we owe to his autonomy. If the court does not have enough information about the patient's subjective preferences, the substituted judgment standard is inappropriate.

b) Closure for relatives and friends. Very often family members or close friends serve as the patient's legal guardian. They will likely know the patient well and have a good grasp on the patient's preferences and desired medical treatment. The substituted judgment standard allows them to express these preferences for the patient. Because it considers previously expressed preferences, substituted judgment would likely be the standard that guardians would prefer.

The benefit of the substituted judgment standard to family and friends can be understood by examining what would happen if the best interests standard were used instead. If the patient had idiosyncratic preferences that are against his best interests and the best interests standard is used nonetheless, the guardians may feel that the decisionmaker made the wrong choice. This may leave guardians and other surrogate decisionmakers with less respect for the legal system and a feeling that their family

⁷⁷ Robertson, 76 Colum L Rev at 63 (cited in note 2).

⁷⁸ *In re A.C.*, 573 A2d at 1250.

⁷⁹ *Id.* at 1251.

⁸⁰ *Id.*

member or friend has been cheated by the law.⁸¹ For example, imagine that an adult, while competent, expressed to his parents his desire to donate a kidney to his sick sister. If that adult later becomes incompetent and the best interests standard prevents the incompetent adult from donating, the parents may feel that the law utterly failed to honor their child's wishes and violated his autonomy to make that choice. This example is equally strong in the situation of an elder adult parent who expressed his desire to sacrifice anything for the well-being of his children. If this elder adult loses his decision-making capacity and, thus, is legally incompetent, the best interests standard may not allow him to be a donor for his child. This is an important consideration because when people feel that the law is not adequately addressing their circumstances, they may resort to extra-legal means to reach their ends.⁸² In the organ donation context, people could use a black market for organs or find an unethical doctor to do the transplant without legal approval.⁸³ If this became common practice, it would seriously weaken the legal system's ability to prevent the harvesting of incompetent patients for organs. Therefore, it is important that people who must deal with the law feel that it treats them, and their loved ones, fairly. The substituted judgment standard achieves that goal.

However, if the legal system's main concern is respecting the patient's autonomy, how the family and friends feel about the decision may be wholly irrelevant to the choice of a standard. How the family and friends feel about the decision would be a benefit mainly from a practical point of view (addressing the concerns raised about respect for the legal system), rather than a benefit out of concern for the patient. Additionally, if the guardian is court-appointed and does not know the patient well, this benefit will not be applicable.

⁸¹ Consider Dworkin, 13 Health Matrix at 280 (cited in note 10) ("Every significant decision about a patient's health may have an impact on that person's relatives, dependents, and others."); Robert M. Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 Am J L and Med 427, 447-48 (1984) ("A [family member or intimate friend], understanding the patient better than would a stranger, is better equipped to interpret the patient's desires.").

⁸² See, for example, Joe A. Flores, *International Scientific Misconduct and the Legal System*, 9 Currents Int'l Trade L J 60, 65 (2000) (describing the international black market in organs that has arisen).

⁸³ Id.

2. Costs.

a) *Personal biases of decisionmaker may be a factor.* The main problem with the substituted judgment standard is that it is, ultimately, just that—someone else's judgment. There is an inherent danger that the decisionmaker will look at the evidence but, in the end, think about what he or she would choose, or allow personal biases to become a factor in some other way.⁸⁴ If this occurs, the standard is not as respectful of the patient's autonomy as it initially appears. This is probably true whether a judge, a doctor, or even the parents make the decision. Each might have different kinds of biases, but all most likely have some biases.

The doctor might think too much in terms of his opinion of the best medical outcome, without taking into consideration other opinions or the patient's idiosyncratic preferences. In the organ donation context for example, a doctor might place too much value on the fact that it could save the recipient's life and that it comes at minimal pain and risk to the donor. This would lead the doctor to more readily determine that the patient would have wanted to donate.

The judge might come to the same conclusion as the doctor by focusing too much on a sense of justice. He might think that donating would be altruistic and the "right" thing for the donor to do. Especially when the recipient is a family member, most people would probably characterize refusing to donate as a selfish act. However, people sometimes have preferences that are not entirely "rational"; some people might simply have an aversion to surgery or feel that they do not want to give up one of their kidneys.⁸⁵ Furthermore, refusing to donate an organ may actually be very rational, if the donor is only interested in his or her own health.

Finally, the parents may value the competent child more than the incompetent child, and may use the substituted judgment standard to save the competent child at the expense of the incompetent one. This valuing may even take place subconsciously, allowing the parents to feel that they have respected

⁸⁴ See Peter Skinner, Note, *Tipping the Scales: How Guardianship of Brandon has Upset Massachusetts' Balanced Substituted Judgment Doctrine*, 40 BC L Rev 969, 987 (1999) ("There is no way of guaranteeing that the biases of the presiding judge will not find their way into substituted judgment decisions.").

⁸⁵ See Robertson, 76 Colum L Rev at 61 (cited in note 2) ("[T]he incompetent, if competent, might not prefer to act as a reasonable person in his circumstances would.").

the incompetent child's wishes and autonomy while in reality allowing their bias toward the competent child to be the deciding factor.

Although being candid about this risk might help to alleviate it somewhat, even the best-intentioned doctor, judge, or parents will have some personal opinions that will at least subconsciously enter into the decision. Limiting the use of the substituted judgment standard to cases where there is a clearly expressed preference, or at least where the patient was previously competent, will help reduce this risk.

b) Factors considered may be irrelevant. Although relying on expressed preferences may be useful, the other factors that are often considered under the substituted judgment standard may have no bearing on whether a patient would have actually wanted to donate.⁸⁶ Factors such as previous medical decisions,⁸⁷ the patient's "value system,"⁸⁸ the patient's "religious beliefs,"⁸⁹ "the impact of the decision on the [patient's] family[,] . . . the probability of adverse side effects[,] . . . the prognosis without treatment[,] . . . [and] the prognosis with treatment,"⁹⁰ are simply ways for the decisionmaker to attempt to understand the patient. But people are complicated; medical decisions, religious beliefs, and value systems may be contradictory or may not reflect preferences for any one particular medical decision. Furthermore, while the final four considerations are things that most patients likely consider when making medical decisions, this may not tell us anything about the weight, if any, that this particular patient would have given to them. Therefore, in the absence of expressed preferences, the likelihood that the decision will accurately reflect what the patient would have done will be much lower. This decrease in accuracy makes the autonomy argument much weaker.

⁸⁶ See Cantor, 48 Rutgers L Rev at 1242 (cited in note 7) ("Substituted judgment fails (in the absence of articulated patient choice) because of its recourse to indeterminate indices, such as patient lifestyle and character, that do not usually answer the critical question of when the patient would prefer [a medical procedure].").

⁸⁷ See *In re A.C.*, 573 A2d at 1250 ("The court should also consider previous decisions of the patient concerning medical treatment."). See also *In re Boyd*, 403 A2d at 751 (holding that when previous actions indicate the patient has a strong adherence to, and has not vacillated from, a particular viewpoint about treatment, that view should be respected).

⁸⁸ *In re A.C.*, 573 A2d at 1250.

⁸⁹ *In re Moe*, 432 NE2d at 723.

⁹⁰ *Rogers*, 458 NE2d at 319.

c) *Inappropriate when the patient was never previously competent.* The situation is further complicated where the patient has never been competent.⁹¹ This would be the case where the patient was born severely mentally impaired or became severely mentally impaired while still a child. When a patient has never previously been competent, substituted judgment truly is a legal fiction.⁹² The most important consideration for substituted judgment is anything that the patient may have said while competent that relates to the decision at hand.⁹³ This kind of evidence will be unavailable in the case of a patient who has never been competent. Other important evidence includes any previous medical decisions that the patient has made, and the patient's value system and/or religious beliefs.⁹⁴ Again, this evidence will not be available where the patient has never been competent. Basing a substituted judgment on the remaining considerations—including "the impact of the decision on the [patient's] family[,] . . . the probability of adverse side effects[,] . . . the prognosis without treatment[,] . . . the prognosis with treatment[,] . . . [and] any other factors which appear relevant"⁹⁵—without any information about the patient's prior preferences, is just the best interests standard in disguise. Pretending to recognize a patient's autonomy⁹⁶ while actually using a best interests standard has the additional risk of leading to outcomes not in the patient's best interests.⁹⁷ The substituted judgment standard, therefore, should not be used where the patient has never been competent.

⁹¹ See Cantor, 48 Rutgers L Rev at 1214-21 (cited in note 7) ("Use of substituted judgment terminology in the context of never-competent patients is, indeed, confusing." Id at 1215.).

⁹² See Morley, 111 Yale L J at 1234 (cited in note 13) ("With regard to nonmature minors and individuals who have been legally incompetent their entire lives, it is impossible to ascertain their 'likely treatment/nontreatment preferences.'") (citations omitted). See also *In re Conroy*, 486 A2d at 1231 ("[I]n the absence of adequate proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making.") (citations omitted).

⁹³ *In re A.C.*, 573 A2d at 1250.

⁹⁴ Id.

⁹⁵ *Rogers*, 458 NE2d at 319.

⁹⁶ If autonomy is the right to self-determination, it could be argued that a patient who has never been competent does not have an interest in autonomy. However, that is a philosophical debate that is beyond the scope of this Comment. Instead, this Comment proceeds on the assumption that even patients who have been incompetent for their entire lives have an interest in autonomy.

⁹⁷ See Cantor, 13 Ann Health L at 43 (cited in note 28) ("Others . . . criticize surrogate decision-making on behalf of profoundly disabled persons because of the potential for abuse.").

The arguments in this section also apply to a patient who was previously competent but had no close friends or relatives who can testify to his previously expressed preferences, values, or religious beliefs.

D. Best Interests Standard

Courts have also used a best interests of the patient standard to make medical decisions for incompetent patients. This standard takes two different forms: the "limited-objective" test and the "pure-objective" test.⁹⁸

Some courts use the limited-objective test when there is "some trustworthy evidence" as to the patient's prior wishes, but not enough evidence to satisfy the substituted judgment standard.⁹⁹ One court explained that this would be the case when the patient "has not unequivocally expressed his desires before becoming incompetent."¹⁰⁰ For example, "informally expressed reactions to other people's medical conditions and treatment" would be enough.¹⁰¹ In other words, the preferences need not have been expressed so clearly as to permit no question, but they should at least have some relation to the proposed treatment. After considering evidence of the patient's wishes, the court weighs the burdens and the benefits to the patient of performing the procedure.¹⁰² In *In re Conroy*,¹⁰³ the court was careful to stress that the burdens and benefits that it would look to would be based on "medical evidence," and that "the degree, expected duration, and constancy of pain with and without treatment" were important considerations.¹⁰⁴ This test combines the subjective viewpoint of the substituted judgment standard with the objective viewpoint of considering what choice is in the patient's best interests.

The pure-objective test looks solely to the net of the burdens and benefits to the patient of having or not having the treatment. Evidence of the patient's desires regarding medical treatment "is not necessary under this pure-objective test."¹⁰⁵ When

⁹⁸ For a general discussion, see *In re Conroy*, 486 A2d at 1209 (discussing the two best interests tests, the limited and the pure objective tests).

⁹⁹ *Id.* at 1232.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² See *In re Conroy*, 486 A2d at 1232 (stating that it must be clear that the benefits of the decision outweigh the burdens).

¹⁰³ 486 A2d 1209 (NJ 1985).

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

explaining what the best interests of the patient are, one court noted that, "it is appropriate to presume that an incompetent individual would choose in a manner similar to others in the same circumstances."¹⁰⁶ It appears that this version of the best interests standard is what most courts have in mind when they reference a best interests standard.¹⁰⁷ In *Little v Little*, for example, the court expressly stated that it would base its opinion on "the benefits that the incompetent donor would derive."¹⁰⁸

For both the limited-objective and the pure-objective tests, courts look to precedent to determine what factors to consider, unless the state had enacted a statute listing which factors the court must consider. In the context of organ donation, risks to the donor include risks associated with all major surgeries¹⁰⁹ and the only real benefit to the donor would be a psychological one.¹¹⁰ This would be the case if, as in *Strunk v Strunk*, the patient is close to the recipient and would benefit psychologically from a continued relationship with him.¹¹¹ In that case, the court emphasized that the practice of organ donation was "becoming increasingly common" and that there was "minimal danger to both the donor and donee."¹¹² It followed that, for Jerry Strunk, the small risks of donation were outweighed by the psychological

¹⁰⁶ *United States v Charters*, 829 F2d 479, 498 (4th Cir 1987).

¹⁰⁷ See, for example, *id* (explaining that "[i]f it is not possible to ascertain what [the patient] would have done were he competent," then the court should use the best interests standard).

¹⁰⁸ 576 SW2d at 498. The court in *Little* approved of the donation because there was evidence of "a close relationship" and evidence that "[the incompetent donor sister] understands the concept of absence and that she is unhappy on the occasions when [the recipient sibling] must leave." *Id*. Furthermore, the court believed that the donor would receive benefits in the form of "heightened self-esteem, enhanced status in the family, renewed meaning in life, and other positive feelings." *Id* at 499. Because any pain and discomfort suffered would be minimal, they believed the costs were outweighed by the benefits. *Id* at 500.

¹⁰⁹ See Strong and Lynch, *Ethical Issues in Living Related Donor Liver Transplantation* at 44 (cited in note 15) ("The risk to the donor is that associated with a major operation in the form of perioperative complications and long-term sequelae."); Spital, *Ethical Issues in Living Related Donors* at 103 (cited in note 15) ("Donor nephrectomy is a major surgical procedure and postoperative complications are inevitable . . . average postoperative complication rate of 32% . . . most of these were minor.").

¹¹⁰ See Strong and Lynch, *Ethical Issues in Living Related Donor Liver Transplantation* at 44 (cited in note 15) ("The only benefit is a psychological one."). An organ donor may also receive other benefits such as gifts from family members, but this begins to look like the donor is being paid for the organ. The benefits that courts look to exclusively are medical or psychological benefits; as there are no medical benefits to donating an organ; the only benefit is a psychological benefit.

¹¹¹ *Strunk*, 445 SW2d at 146-47.

¹¹² *Id* at 148.

benefit the donor would receive.¹¹³ Because there is no physical benefit to the patient, the psychological benefits should be especially strong to justify the physical risks associated with organ donation.¹¹⁴

The main benefit of the best interests standard is that it is more objective than the substituted judgment standard. However, it may not adequately respect the patient's autonomy and it may rely on immeasurable elements. This section will elaborate on these ideas.

1. Benefits.

a) Personal biases less likely to be a factor. The best interests standard is either a limited- or pure-objective standard. Because of this objectivity, it is less open to the possibility of personal biases entering into the decision. When all decisionmakers use the same rules and consider the same benefits and burdens, there is less opportunity for the decisionmaker to depart from the stated rule. Also, if the decisionmaker does depart from the rule, the fact that the rule was laid out in advance will allow those reviewing the decision to see this departure and remedy it.

On the other hand, this objective test is not able to get the subjectively "right" result every time (where "right" refers to what the patient would have decided if he had the decisionmaking capacity¹¹⁵). This reflects the classic "rules versus discretion" problem. A blanket rule may not be appropriate in every case, but it ensures that there will be little room for abuse of the system. Alternatively, a discretionary system has the possibility of getting the "right" answer every time but opens the door to intentional, or even unintentional, abuse because decisionmakers lack significant guidance. As such, under a best interests standard, courts might not get the right result every time. As noted above, people might have idiosyncratic preferences that would lead them to do what is not in their best interest. However, courts can be confident that if they use the same standard every time, they will reflect the preferences of the majority of the people. Alternatively, with an individualized assessment every

¹¹³ Id at 149.

¹¹⁴ See, for example, Spital, *Ethical Issues in Living Related Donors* at 103 (cited in note 15) (endorsing living related donation when "large psychological benefits" outweigh the "small risk to the donor").

¹¹⁵ It is clear that we can never know what the patient would have done, unless of course they suddenly regain competency and tell us. However, this argument relies on the assumption that there is such a "right" result and we are attempting to reach it.

time,¹¹⁶ the decisionmaker's preferences and biases can become part of the decision even if the decisionmaker does not realize their influence.¹¹⁷ This creates a very real possibility that we will get the right answer much less often. With an objective test, such as the best interests standard, this is less likely to happen because there will be general rules that are followed in every case.

b) *More realistic for the never-competent patient.* In contrast to the substituted judgment standard, the best interests standard is the most realistic way to address the situation where the patient has never been competent.¹¹⁸ As noted above, without any information about what the patient's prior preferences were, the substituted judgment standard essentially becomes a best interests standard anyway. Officially recognizing that the standard is attempting to determine what is in the patient's best interests will help ensure that the decision is *actually* in the patient's best interests. This standard prevents the decisionmaker from imposing his own beliefs on the patient. Admittedly, this may still happen. Again, a doctor who believes that there is little pain or risk involved in an organ donation may believe that it is in the patient's best interest to donate. However, while the substituted judgment standard takes into account the effect on the family and other outside interests, the best interests standard looks solely to the interests of the patient. The former might be used to push aside the interests of the patient while mainly looking out for those whose lives seem to be more "valuable." This may lead the decisionmaker to order the organ removed to save the life of a competent individual even at risk to the incompetent patient. The best interests standard, on the other hand, considers the incompetent patient's life to be an end in itself requiring that the decisionmaker protect the patient's best interests.¹¹⁹

¹¹⁶ Although the best interests standard could be called individualized in that it considers the costs and benefits to the individual patient, the substituted judgment standard is more individualized because it considers what this patient *actually* would have wanted.

¹¹⁷ See Skinner, 40 BC L Rev at 987 (cited in note 84) ("There is no way of guaranteeing that the biases of the presiding judge will not find their way into substituted judgment decisions.").

¹¹⁸ See, for example, *Curran*, 566 NE2d at 1325-26. The court notes that, "it is not possible to determine the intent of a 3 1/2-year-old child with regard to consenting to a bone marrow harvesting procedure by examining the child's personal value system." Id at 1326.

¹¹⁹ Additionally, part of the solution to the problem might be in choosing the best decisionmaker. See Part IV.

2. Costs.

a) May not respect the patient's autonomy. The best interests standard does not take into account the patient's actual preferences, which may result in not enough respect being given to the patient's autonomy. In an individualized society such as America, we place great weight on the right of the individual to determine his own destiny. Where the patient has previously been competent, even if there is no advance health care directive, many people would be uncomfortable with the idea of not even trying to determine what the patient's actual preferences would be. People may feel that if they were incompetent, they would not want someone to make a decision for them that did not conform to their preferences. Even though the patient may have no awareness of the decision, he is still a human with equal rights and, therefore, society must attempt to determine what he would choose to do if he were competent to make the decision.

The limited-objective test, as described above, might address this problem. That test considers any reliable information about the patient's subjective preferences.¹²⁰ This respects the autonomy of the patient to the extent that there is available information about what decision the patient would make. It also protects the autonomy of the patient because in the absence of enough information to make a determination, it looks to the best interests of the patient. This prevents the biases of the decisionmaker from entering into the decision. It also prevents the decisionmaker from making a decision based on the effects of the decision on others, rather than on the patient. However, administration of this standard would require a threshold determination of whether there is reliable information. Decisionmakers may have differing standards about what constitutes reliable information, and may give different weight to any information that is available. This would weaken the standard and again open it up to abuse by the decisionmaker.

b) Relies on immeasurable elements. The best interests standard weighs the burdens and benefits of the decision. Examples of factors that the standard looks to are: "the degree, expected duration, and constancy of pain with and without treatment."¹²¹ These considerations and others like them may be im-

¹²⁰ *In re Conroy*, 486 A2d at 1232.

¹²¹ *Id.*

possible to quantify.¹²² For example, in the medical community, pain is always considered a subjective experience.¹²³ Each person's conception of pain is different, which makes it very difficult to compare pain quantitatively. Furthermore, in the context of organ donation, the only benefit to the donor will be a psychological one, which is also very difficult to quantify. Because the objectivity of the standard depends on the weighing of these factors, if the factors cannot be assigned an objective weight, then the decisionmaker is placing values on the factors according to his or her own value system, and the standard is no longer really objective. In that case, it may be better to use a subjective standard because it will at least take into consideration the patient's autonomy.

Where the patient has never been competent, however, these concerns do not outweigh the concern that the substituted judgment standard is a legal fiction. In that case, even if measuring these standards is difficult, the best interests standard will at least attempt to do what is best for the patient.¹²⁴

III. ALTERNATIVE APPROACHES

Some commentators, dissatisfied with the current state of the doctrine, have proposed alternative approaches to dealing with this issue. These include: the utilitarian approach, the constructive preferences standard, prohibiting incompetent patients from donating organs, and a reasonableness standard for bonded guardians. An examination of each of these alternatives demonstrates that none meets the unique requirements of the never-competent-incompetent-donor problem while at the same time respecting the previously competent donor's autonomy.

A. Utilitarian Approach

One proposed alternative is a purely utilitarian approach.¹²⁵ This involves weighing the benefits and burdens of the decision,

¹²² Cantor, 48 Rutgers L Rev at 1242 (cited in note 7).

¹²³ See C. David Tollison, John R. Satterthwaite, and Joseph W. Tollison, eds, 2 *Handbook of Pain Management* 3 (Williams and Wilkins 1994) ("Pain is always subjective.").

¹²⁴ See Part II.A.2.c discussing the costs of using substituted judgment when the patient has never been competent and Part II.B.1.b discussing the benefits of using best interests when the patient has never been competent.

¹²⁵ For a general discussion, see Robertson, 76 Colum L Rev at 50-52 (cited in note 2) (describing the utilitarian approach to organ donation and noting the costs and benefits of that approach).

not only to the individual and the family, but also to the recipient of the organ and to society as a whole. Concerns such as increased health care costs for society (if the patient is a ward of the state or is otherwise supported by the state) and the benefit of reducing organ transfer waiting lists are considered. Additionally, the benefits and burdens to the recipient are considered. Therefore, if the donation posed little risk to the donor and would be the only way to save the recipient's life, the utilitarian approach would almost certainly call for the donation to take place. Although these concerns might already be in the back of people's minds when making decisions under either of the other two standards, this approach would bring the concerns into the open. This would be good because transparency ensures that the decision is made according to the standard that has been chosen. With the substituted judgment and best interests standards, these considerations are not technically part of the equation, but most likely still play at least a minor role.

Concerns about patient autonomy that are present under the best interests standard, though, are much greater under a utilitarian approach.¹²⁶ Depending on the benefits and burdens that come into play, the utilitarian approach could lead to a determination directly against the interests of the patient. If the donation poses a substantial risk to the donor but would save the life of the recipient, allow someone else to get an organ from the waiting list, and save costs to society because the recipient would no longer be using up health care dollars, then the utilitarian approach would approve of the donation. Depending on the extent of the risk to the donor and the preferences that the donor may have expressed in the past, this result could be the exact opposite of the result that both other standards would reach. This would, however, be highly contingent upon how much weight each factor is given. If courts give the patient's right to self-determination greater weight than factors that do not directly concern the patient, the risk might be reduced.

This highlights another problem with the utilitarian approach: the calculations required under this approach call for placing a quantitative value on interests that may be nearly impossible to quantify. How much value to give a patient's autonomy interests versus how much value to give meeting the demand for organ donations is not a simple decision. This is similar to the problem discussed in the context of the best interests

¹²⁶ *Id.* at 51 ("[U]tilitarianism conflicts with the strictest respect for persons.").

standard, although it is magnified due to the additional (social and other) factors considered. In light of this problem, the utilitarian approach may become simply a way for the decisionmaker to make the decision according to his value system, rather than a determination based on the factors set out to be weighed.

B. Constructive Preferences Standard

Norman L. Cantor has suggested that courts should use a "constructive preferences" standard.¹²⁷ This standard, which the author deals with in terms of dying patients, focuses on the dignity of the individual in arguing that dignity is the driving force behind most end-of-life decisions. The constructive preferences approach seems to apply a "reasonable person" standard to these kinds of medical decisions, focusing on what most people would want under these circumstances.¹²⁸ It is only applicable when the patient previously was competent and had not executed any advance health care directives.¹²⁹ Although the approach is directed at dying patients or those in a persistent vegetative state, it could most likely be applied effectively in the organ donation context.¹³⁰

This at first glance might seem like the best interests standard—it is an objective approach that does not focus on the subjective preferences of the particular patient. However, because it focuses on what most people would actually do, it might be better than the best interests standard. This standard could reflect people's generalized preferences that go against their best interests. For example, in the end-of-life context, it is against a patient's medical "best interest" to want to end his or her life. But if this were what most people would want under the circumstances, the constructive preferences approach would reflect that choice.

The problems with this approach are two-fold. First, who decides what most people would actually want in the circum-

¹²⁷ See Cantor, 48 Rutgers L Rev 1193 (cited in note 7) (describing the constructive preferences standard).

¹²⁸ Id at 1246 ("By utilizing common preferences about intolerable dignity, the incompetent is treated with the respect and dignity that most people would expect for themselves.") (citation omitted).

¹²⁹ Id at 1242.

¹³⁰ Cantor is mainly concerned with remedying the faults of both the substituted judgment and the best interests standards. Because both standards are also used in the organ donation context, the constructive preferences standard could potentially remedy their faults there as well.

stances?¹³¹ A judge? A doctor? A legislator? An academic?¹³² Second, if there is to be an objective standard, will it be based on surveys, anecdotal evidence, or something else? If the constructive preference is to be decided by the decisionmaker in the individual case, it really becomes just another vehicle for that decisionmaker to project his own beliefs about what he would want done onto everyone else and, more importantly, onto the patient. Because the author suggests that this should only apply where the patient has left no advance health care directive, the problems with patient autonomy may not be present. However, where the patient has expressed his preferences in a more informal way, such as by expressing his wishes to a close loved one, not honoring those preferences may be denying the patient's autonomy.

C. Prohibiting Organ Donation by Incompetent Patients

Another approach would prohibit organ donation by incompetent patients in all cases.¹³³ One commentator argues that a best interests standard is inappropriate because "courts refuse such a balance of benefits and harms when asked to compel competent adults to donate organs."¹³⁴ Because a court would never compel a competent adult to donate, incompetent patients should also be protected from being compelled to donate. Categorically prohibiting organ donation by incompetent patients would ostensibly prevent abuse of incompetent patients and would get around the failures of both the substituted judgment and best interests standards.

In that it side steps the issue entirely, this approach does not share the flaws of the substituted judgment or best interests standards. However, as discussed above, prohibiting organ donation by incompetent patients may not in fact respect a patient's

¹³¹ Although any approach will have a similar problem, the problem is unique under this standard. Here, the decisionmaker is attempting to determine what most people would want, rather than just what this particular person would want. Under the substituted judgment standard, the decisionmaker is deciding what *this* patient actually would want. Under the best interests standard the decisionmaker is deciding what is in *this* patient's actual best interests. Both of those inquiries are very different than deciding what *most people* would actually want.

¹³² An interesting point is that all of these potential decisionmakers are members of society's elite and they might project their view of the value of life onto people who may have radically different priorities than they do.

¹³³ For a general discussion, see Cheyette, 41 BC L Rev 465 (cited in note 16) (arguing that incompetent patients should never be allowed to donate organs).

¹³⁴ Id at 469.

autonomy where that patient had desired to donate organs.¹³⁵ Given the autonomy concerns, the low risk to the donor, and the enormous potential benefits, this argument is an attempt to reach a simple solution to a complicated problem and, as a result, the argument fails to reach the nuances of this problem.¹³⁶ The autonomy argument alone is important enough (both legally and ethically) to demand that we find a standard whereby patients who had, or would have, desired to donate organs could do so.

Where the patient has never been competent, there might be an argument for prohibiting organ donation entirely. However, some patients who are not competent to make medical decisions are still competent enough to have valuable relationships with family members. Therefore, it seems that there is a very real possibility of a donor reaping psychological benefits from donation.

D. Reasonableness Standard for Bonded Guardians

Another alternative approach that has been proposed would grant bonded guardians broad discretion over the medical decisions of their incompetent wards.¹³⁷ Bonded guardians are those guardians "who had a bond with the patient that preexisted the guardian-patient relationship,"¹³⁸ such as a family member or close friend. Under the reasonableness standard, the bonded guardian would have the discretion to make "those decisions that would be both legal and ethical."¹³⁹ The reasonableness standard for bonded guardians is proposed in the context of refusing treatment, although it could almost certainly be adapted to the organ donation context.

In the case of a minor child, this standard seems to make sense. Even with an adult child, many people would consider the parent the best decisionmaker. However, when two children are involved the parent may be overly concerned about the welfare of

¹³⁵ See Part II.A.1.a (discussing the reasons that prohibiting organ donation by incompetent patients under all circumstances would not respect their autonomy).

¹³⁶ We sometimes use simple solutions for complicated problems. For example, we prohibit selling organs despite some of the same concerns. An important distinction, though, is that with organ donation competent people are allowed to donate, whereas this solution would prohibit all incompetent people from donating, regardless of the degree of incompetence or the patient's previously expressed wishes.

¹³⁷ For a general discussion, see Veatch, 9 Am J L and Med 427 (cited in note 81) (arguing that bonded guardians should be given broad discretion).

¹³⁸ Id at 428.

¹³⁹ Id at 434.

the competent sibling who would receive the organ and not as concerned with the incompetent sibling's welfare. Furthermore, if the parent or guardian had ultimate control over the decision, this decision would be almost impossible to review. In the case of an adult child, concern over that adult's autonomy should outweigh the parent's, or bonded guardian's, interests in the decisionmaking.

Another problem with this standard is the use of the inherently value laden terms "legal" and "ethical." Who decides which decisions are legal and which are ethical? If a court is reviewing the guardian's decisions to make sure that they are legal and ethical, isn't the court essentially making the decision? And if the court does not review the decision, how can we be sure that it truly is legal and ethical? These problems illustrate that holding bonded guardians to a reasonableness standard is not satisfactory.

IV. THE DECISIONMAKER

There is an animated debate over whether a court, a doctor, a guardian acting alone, or some other decisionmaker should make the determination of whether the incompetent patient will be an organ donor. *Washington v Harper*,¹⁴⁰ a Supreme Court case addressing prisoners' medical rights, held that a medical professional could exercise substituted judgment for an incompetent prisoner, and that due process concerns did not require a court to make the determination.¹⁴¹ Quoting a previous case, the Court explained, "we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing."¹⁴² The Court stopped short, though, of saying that a judge could never make the decision.¹⁴³ In light of this, some state courts have required a judicial determination.¹⁴⁴ The current state of the law is therefore mixed between

¹⁴⁰ 494 US 210 (1990).

¹⁴¹ *Id.*

¹⁴² *Id.* at 232 (quoting *Parham v J.R.*, 442 US 584, 609 (1979) (internal quotation marks omitted)).

¹⁴³ The question at issue in the case was "whether a judicial hearing is required." *Id.* at 213. Therefore, the Court only addressed whether a judicial hearing was required, not whether it was allowed.

¹⁴⁴ See, for example, *Rogers*, 458 NE2d 308, 310 (Mass 1983) ("If a patient is adjudicated incompetent, a judge, using a substituted-judgment standard, shall decide whether

judges and medical professionals making these important determinations for the incompetent patient. Each approach has benefits, but there are also costs involved.

Doctors might argue that they should make these decisions because they have a better understanding of the medical issues at stake and the effects of the procedure on the patient. Furthermore, a doctor may have worked with the patient for a long time and thus know his condition and, possibly, his family. Also, doctors may believe that it is a waste of time and resources to go to a judge, especially because the patient may die while waiting for a judge's decision which makes the organ potentially unusable. On the other hand, doctors may allow the potential benefits to the recipient and the low risk to the donor to cloud their vision. They may neglect to consider any previously expressed preferences and values, or what is truly in the donor's best interests.

Judges might argue that medical expertise is not necessary to make the correct decision. The patient, if competent, would likely have about the same level of medical knowledge as the court. Therefore, a judge might be in a better position than a doctor to decide what the patient really would have wanted. Furthermore, because the judge is presumably impartial, he might not be as influenced by the potential benefit to the recipient of the organ transfer. Another benefit is that the judge's decision is reviewable. If the surrogate is not happy with the doctor's decision, it might be harder to get the decision overturned. A judge's ruling, though, can be appealed. On the other hand, the judge may have strong convictions about what "justice" requires and put those convictions above the patient's autonomy. A concern that should be considered with both a doctor and a judge is that any individual acting alone may be unethical.

One commentator has argued that the parent or guardian should have broad control, at least where the guardian is "bonded" to the patient.¹⁴⁵ As the discussion above highlights, however, this standard has drawbacks that make it an unattractive option.¹⁴⁶

the patient would have consented [to the treatment]."); *Saikewicz*, 370 NE2d at 433 ("The Probate Court is . . . the proper tribunal to determine the best interests of a ward.").

¹⁴⁵ Veatch, 9 Am J L and Med at 428 (cited in note 81) (arguing for broad discretion for "a guardian who had a bond with the patient that preexisted the guardian-patient relationship").

¹⁴⁶ See Part III.D.

Some hospitals use a hospital ethics committee or review board to determine whether an incompetent patient should be allowed to donate an organ.¹⁴⁷ Multiple doctors, ethicists, religious experts, social workers, lawyers, and even judges may sit on the board.¹⁴⁸ The participation of multiple people ensures that one person's viewpoint does not dominate the decision, and, furthermore, that the decision is more likely to be free of corruption or unethical motives. Having doctors on the board provides the medical expertise, and the ethicist or judge might bring to the table ideas about justice. Often the doctor who is working directly with the patient will not sit on the board, so that it will be more objective—although the doctor could sit on the board to provide a more personal understanding of the situation. This alternative seems to combine the benefits of both the judge and the doctor, while canceling out some of the costs of having one or the other as the sole decisionmaker.

V. RECOMMENDATION

Resolving the issues of what standard should be used and who should make the decision is complicated and involves many considerations. The discussion above has highlighted the most important considerations in determining if an incompetent person should be able to donate their organs and leads to the recommendation that follows.

The substituted judgment standard should be used when there is reliable evidence as to the patient's preferences for treatment under the circumstances. Reliable evidence would include both written statements and statements made to family members or close friends during serious discussions about the issue. Comments made during casual conversation or not directly related to the topic should not be considered. Other factors often considered, such as previous medical decisions, religious beliefs, and the effect on family and friends, should not be used. When the patient has never been competent, or when there is inadequate information about the patient's prior preferences, the best interests standard should be used. Donating an organ will only be in the patient's best interest if it will have a psychological benefit. This will require proof that the incompetent patient has

¹⁴⁷ For a general discussion, see Brendan Minogue, *Bioethics: A Committee Approach* (Jones and Bartlett 1996) (describing the make-up and function of a hospital ethics committee).

¹⁴⁸ *Id.* at 3.

a relationship with the recipient and benefits from this relationship. In sum, when there is no evidence of a patient's preferences, the decisionmaker should weigh the potential psychological benefits against the risks of donation and determine what is in the patient's best interests.

Using the substituted judgment standard when there are clearly expressed preferences will respect the patient's autonomy and his right to choose organ donation. The substituted judgment standard also reflects a belief that individualized decisions, based on adequate evidence, will lead to the best results. On the other hand, when the patient has never been competent, the best interests of the patient standard will ensure that incompetent patients' rights and autonomy are protected. Incompetent individuals will not be used for harvesting organs when it is against their best interests. Where there is no reliable evidence of an incompetent individual's wishes, autonomy is better served by ensuring the most objective decisionmaker possible.

Alternatives have been presented to deal with these problems. However, none of the alternatives proposed have adequately alleviated these problems without raising other, potentially more serious, problems.

Deciding who the decisionmaker should be is just as important as what standard that decisionmaker should use. A judge, a doctor, the guardian acting alone, or a hospital review board could make the decision about whether to allow donation. The discussion above highlights the costs and benefits of each approach.¹⁴⁹ The best option for the decisionmaker is a hospital ethics committee or review board. A committee will prevent one person's viewpoint or biases from dominating the decision. Furthermore, this approach will ensure that the most objectively correct interpretation of either standard is applied to the particular case.

CONCLUSION

Incompetent patients cannot make medical decisions for themselves; instead, they rely on their guardians, the legal system, and society to find ways for those medical decisions to be made appropriately. In the context of organ donation, surrogates face a decision that would not necessarily pose a serious risk to the patient, but also may not present an immediate medical

¹⁴⁹ See Part IV.

benefit to the patient. On the other hand, the decision would have the potential to greatly benefit the recipient of the organ. It is against this background that courts and legal commentators have struggled to find a standard that would both respect the autonomy of the incompetent patient and protect that patient's best interests.

The recommendation proposed by this Comment seeks to respect patient autonomy when there is enough evidence to do so. However, it recognizes that, without adequate evidence, the substituted judgment standard will become a forum for the decisionmaker to decide whether he, rather than the patient, would be an organ donor in a similar situation. The recommendation that the best interests standard be used in those cases is an acknowledgment of this concern and an attempt to protect the incompetent patient from abuse. Furthermore, the use of a hospital ethics committee or review board is also a useful attempt to ensure that the patient receives the most unbiased decision that truly reflects either his own preferences or his best interests.